



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
HERITAGE PLACE, METRO CENTER
227 FRENCH LANDING, SUITE 300
NASHVILLE, TN 37243

TENNESSEE BOARD OF DIETITIAN/NUTRITIONIST EXAMINERS
(615) 532-5155 OR 1- 800-778-4123 ext. 25155

www.tennessee.gov

LICENSURE APPLICATION INSTRUCTIONS AND CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

DONE

1. If you have applied to take the American Dietetic Association Examination you may apply for a temporary permit with an additional \$5.00 fee. You must submit proof you are approved to take the exam from A.D.A. and complete steps 2 through 7. _____
2. Complete, sign, have notarized and mail the application pages 1 through 6. _____
3. Submit a signed passport style photograph taken within the preceding 12 months. (applicant must sign front of photo.) Computer generated images are not acceptable. _____
4. Official Transcript - Must be sent to the board directly from the institution. Please instruct the institution to address the transcript to the Board of Dietitian/Nutritionist Examiners, First Floor, Cordell Hull Building, 425 5th Avenue North, Nashville, Tennessee 37247-1010. _____
5. Submit a notarized copy of current registration with the Commission on Dietetic Registration. A legible notarized photo copy of a current registration card with your signature is acceptable. _____
6. Submit one (1) original letter of recommendation from a professional attesting to your personal character and professional ethics. Letter must be on the signature's letterhead written within the past twelve (12) months, and have an original signature. **"No Copies"** _____
7. Submit with your application a check or money order in the amount of **\$140.00** made payable to the State of Tennessee. _____
8. If you are applying through reciprocity complete steps 2 through 8. Complete and mail **Attachment 1** to each state, country, or province in which you hold, or have ever held a license to practice. _____
9. If you are currently taking a chemical substance, request from your medical provider a letter to be sent to the Board indicating the medications will or will not affect your abilities to perform as a Dietitian/Nutritionist. _____
10. All Applicants for the Dietitian/Nutritionist Examiners must complete and return the Mandatory Practitioner Profile Questionnaire. _____
11. A Criminal Background Check is required. For further instructions, please [click here](#) _____

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Board office, in writing, immediately.

1. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

**Board of Dietitian/Nutritionist Examiners
227 French Landing, Suite 300
Heritage Place, Metro Center
Nashville, TN 37243**

OR

**For Federal Express or Special Courier:
Board of Dietitian/Nutritionist Examiners
227 French Landing, Suite 300
Heritage, Place, Metro Center
Nashville, TN 37228**

2. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
3. **We will discuss application status with the applicant or applicant's spouse only.** Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from you.
4. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. Files not completed in a timely manner will be closed.
5. Absent any complicating factors, the average application processing time is **three weeks**. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

Thank you for your cooperation. We will make every effort to process your application in an expeditious and efficient manner.

**PLACE
FULL FACE,
PASSPORT SIZE
PHOTOGRAPH
HERE**



**STATE OF TENNESSEE
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227 FRENCH LANDING, SUITE 300
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Temporary Permit Fee
3955-006 \$ 5.00

Licensure Fees
3955-001 \$ 75.00
3955-001 55.00
3955-006 10.00
\$140.00

**BOARD OF DIETITIAN/NUTRITIONIST EXAMINERS
APPLICATION FOR LICENSURE**

**Local (Nashville Calling Area) 615-532-5155
Nationwide (toll free) 1- 800-778-4123 ext. 25155**

APPLICANT: Read all instructions carefully and complete all portions applicable to you. **Please type or print legibly in ink.** If a question does not apply to you place a **N/A** in the appropriate space.

PERSONAL INFORMATION

Name: _____			
_____	_____	_____	_____
Last	First	Middle	Maiden
Social Security Number: _____ - _____		Date of Birth: _____	
Mailing Address: _____		Practice Address: _____	
_____		_____	
_____		_____	
_____		_____	
Home Phone #: (____) _____ - _____			
Work Phone #: (____) _____ - _____			
Email Address: _____			
County (TN Applicants Only): _____			

The following is collected for statistical purposes only:

OPTIONAL

RACE _____ SEX (M) _____ (F) _____

LICENSE HISTORY

List below all states in which you have ever been or are currently licensed (in any health profession). If you have not previously been licensed, mark this section N/A. NOTE: You must request that each state listed send licensure verification directly to the Tennessee Board. (Reference: Licensure Verification Form Attachment 1).

STATE

LICENSE NUMBER

DATE ISSUED

REGISTRATION

Are you registered by the Commission on Dietetic Registration? Yes ☐ No ☐

Registry Number: _____

Date Registered: _____

Are you a current member of the American Dietetic Association? Yes ☐ No ☐

Initial Membership Date:

Select Current Status:

Active ☐

Retired ☐

Inactive ☐

Student ☐

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all post-secondary educational institutions you have attended. Use the back of this page if you need additional space.

From: _____ To: _____
Mo/Yr Mo/Yr Educational Institution (Dietician/Nutrition) Degree Awarded

From: _____ To: _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

Please complete your entire employment history (relating to dietetics) starting with the most current position first. Use the back of this page if you need additional space.

DATES

LOCATION

POSITION AND DUTIES

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

From: _____ To: _____
Mo/Yr Mo/Yr (City/State)

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and
 - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

	YES	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	—	—
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	—	—
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?	—	—

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:	YES	NO
2. Do you currently use chemical substances?	_____	_____
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety? Submit written explanation of chemical substances.	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5. If you have ever held or applied for a dietitian/nutritionist license or certificate in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
7. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you; or	_____	_____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
8. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
9. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
10. Have you ever been rejected or censured by a professional society?	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include an interview.

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and any other qualifications.

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

In order to comply with federal statutes, the Board of Dietitian/Nutritionist Examiners is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

Sworn to before me, this ____ day of _____, _____.

NOTARY PUBLIC

Affix Seal Here

My Commission expires _____



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
HERITAGE PLACE, METRO CENTER
227 FRENCH LANDING, SUITE 300
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Local (Nashville Calling Area) 615-532-5155
Nationwide (toll free) 1-800-778-4123 ext. 25155

BOARD OF DIETITIAN/NUTRITIONIST EXAMINERS
LICENSURE VERIFICATION

Complete Part 1 of this form and mail to each state in which you hold or have held a license. (You are authorized to photocopy the form). Please note that some states may charge a fee for reporting this information.

PART I - TO BE COMPLETED BY THE APPLICANT

I am applying for a Dietitian/Nutritionist license in Tennessee. I was granted licensure/certification in the State of _____. My license number is _____. The Tennessee Board of Dietitian/Nutritionist Examiners requires that I submit verification that my licensure/certification is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board.

Name (Please Print) _____

Signature _____

**PART II - TO BE COMPLETED BY STATE BOARD
AND SUBMITTED WITH COPY OF LAW, RULES, AND REGULATIONS**

NAME: _____

CERTIFICATION/LICENSE NO. _____

DATE ISSUED: _____ EXPIRATION DATE: _____

LICENSED BY: () Reciprocity/Endorsement
 () Exam, Specify _____
 () Other, Specify _____

Do you show any derogatory information? () Yes () No

If yes, please explain fully on separate sheet.

SIGNATURE _____ BOARD
SEAL

TITLE _____
DATE

State Board: Please return this form to: Board of Dietitian/Nutritionist Examiners
Heritage Place, Metro Center
227 French Landing, Suite 300
Nashville, TN 37243



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
HERITAGE PLACE, METRO CENTER
227 FRENCH LANDING, SUITE 300
NASHVILLE, TN 37243

BOARD OF DIETITIAN/NUTRITIONIST EXAMINERS
(615)-532-5155
1-800-778-4123 ext. 25155

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your educational program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a license or limited permit to practice as an Dietitian/Nutritionist in the State of Tennessee. The Board of Dietitian/Nutritionist requires verification of educational attainment. Please forward an original transcript showing degree awarded and bearing the institution's official seal to the Board's address below.

Applicant's Full Name: _____
(First) (Middle/Maiden) (Last)

Applicant's Address: _____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identified Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

**Board of Dietitian/Nutritionist Examiners
Heritage Place, Metro Center
227 French Landing, Suite 300
Nashville, TN 37243**

Thank you for your cooperation and prompt response.

Applicant's Signature Date

TENNESSEE DEPARTMENT OF
HEALTH

**MANDATORY
PRACTITIONER
PROFILE QUESTIONNAIRE**

**PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq,
LAWS OF TENNESSEE**

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWARD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: <http://tennessee.gov/health>.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

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SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the “Does not apply” box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the “Does not apply” box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state’s licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- Mail the completed ORIGINAL profile questionnaire within thirty (30) days of its receipt by the provider to:

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- Keep a copy of the questionnaire for your records.

✓CHECKLIST

Before you mail your questionnaire:

Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the “Does not apply” box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in “N/A” for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a “yes” answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required

Practitioner's Name _____ License # _____
Profession _____

SECTION III:

**HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243**

I. PRACTITIONER DATA

A.	PROFESSIONAL LICENSE NUMBER: _____	PROFESSION: _____
B.	SOCIAL SECURITY NUMBER: _____ (This will not be published as part of the profile or website).	
C.	NAME (INCLUDE MAIDEN AND ON 2 ND /3 RD LINES ANY ALIASES, IF APPLICABLE): CURRENT NAME:	
	(LAST)	(FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)
	FORMER NAME(S):	
	(LAST)	(FIRST) (MIDDLE)
	(LAST)	(FIRST) (MIDDLE)
D.	MAILING ADDRESS:	
	(STREET AND NUMBER)	
	(CITY)	(STATE) (ZIP CODE)
	PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).	
	(PRACTICE NAME)	
	(STREET AND NUMBER)	
	(CITY)	(STATE) (ZIP CODE)
E.	TELEPHONE: (____) _____ (This will not be published as part of the profile or the web site).	
F.	LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.	
	1. _____	
	2. _____	
G.	SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:	
	1. _____	
	2. _____	

Practitioner's Name _____ License # _____
 Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY, STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ License # _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ☐ NO ☐

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ☐ NO ☐

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ☐ NO ☐

If "YES", list the title of the appointment and name(s) and city/state of institution(s).
(Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ☐ NO ☐

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

Name of Hospital	City/State
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Practitioner's Name _____ License # _____
Profession _____

- B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ☐ NO ☐
If "YES", list each plan in which you currently participate:

Name of TennCare Plan

1. _____
2. _____
3. _____
4. _____
5. _____

VI. FINAL DISCIPLINARY ACTION (See Instructions)

- A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ☐ NO ☐

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

2.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

3.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

Practitioner's Name _____ License # _____
Profession _____

- B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ☐ NO ☐

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
---------------	------	--------------------------	-----------------------

- | | | | |
|----|-------|-------|-------|
| 1. | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

- | | | | |
|----|-------|-------|-------|
| 2. | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

- | | | | |
|----|-------|-------|-------|
| 3. | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

- C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ☐ NO ☐

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
---------------	------	-----------------------

- | | | |
|----|-------|-------|
| 1. | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

- | | | |
|----|-------|-------|
| 2. | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

- | | | |
|----|-------|-------|
| 3. | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

Practitioner's Name _____ License # _____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s):

YES ☐ NO ☐

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.	_____	_____	_____
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	_____	_____	_____
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	_____	_____	_____
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.	_____	_____
2.	_____	_____
3.	_____	_____

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

(Signature of Provider)
YB/G6019027/RTK-ms.70

Date: _____